

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/25/2011
NAME OF PROVIDER OR SUPPLIER GREYSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 001	1200-8-6 Initial Comments During the onsite investigation of complaint # 28715, # 28737, and # 28749, conducted on September 27 - 29, 2011, at Greystone Health Care Center, no deficient practices were cited under Chapter 1200-8-6, Standards for Nursing Homes.		N 001		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

TD7F11

TITLE

(X6) DATE

Karen L. Lutz
Administrator

11/10/2011

If continuation sheet 1 of 1

NOV 16 2011